



General

Title

Heart failure (HF): percentage of HF patients discharged from a hospital inpatient setting to home or home care for whom a care transition record is transmitted to a next level of care provider within 7 days of discharge containing the specified information.

Source(s)

The Joint Commission. Disease-specific care certification program. Advanced certification heart failure: performance measurement implementation guide. Oakbrook Terrace (IL): The Joint Commission; 2015 Mar. 76 p.

Measure Domain

Primary Measure Domain

Clinical Quality Measures: Process

Secondary Measure Domain

Does not apply to this measure

Brief Abstract

Description

This measure is used to assess the percentage of heart failure (HF) patients discharged from a hospital inpatient setting to home or home care for whom a care transition record is transmitted to a next level of care provider within 7 days of discharge containing ALL of the following:

Reason for hospitalization

Procedures performed during this hospitalization

Treatment(s)/service(s) provided during this hospitalization

Discharge medications, including dosage and indication for use

Follow-up treatment and services needed (e.g., post-discharge therapy, oxygen therapy, durable medical equipment)

Rationale

The hand-over of care from one healthcare provider to another should smooth the transition of care from the inpatient to outpatient setting (van Walraven et al., 2002). Communication and information exchange should be completed to allow sufficient time for the receiving provider to treat the patient. The timeliness of communication should be consistent with the urgency of follow-up required (Kripalani et al., 2007). Communication and information exchange between providers may be in the form of a phone call, fax, or other secure vehicle, such as, mutual access to an electronic health record (EHR).

The Joint Commission's 2014 Disease-Specific Care Advanced Certification Heart Failure standards require: The program [to provide] care coordination services across inpatient and outpatient settings. Requirements specific to heart failure care certification include:

The program identifies an individual to coordinate the care of participants.

The program provides participants with access to a practitioner 24 hours a day, 7 days a week (access may include use of the telephone and the internet, and referral to urgent care settings). The program communicates important information regarding co-occurring conditions and co-morbidities to appropriate practitioner(s) to treat or manage conditions.

The program care coordinator(s) is responsible for the communication of relevant information among practitioners and across settings.

The program care coordinator(s) is responsible for sharing information among practitioners in a timeframe that meets the participant's needs.

The program care coordinator(s) is responsible for confirming practitioner receipt of information and actions taken.

Evidence for Rationale

Bell CM, Schnipper JL, Auerbach AD, Kaboli PJ, Wetterneck TB, Gonzales DV, Arora VM, Zhang JX, Meltzer DO. Association of communication between hospital-based physicians and primary care providers with patient outcomes. J Gen Intern Med. 2009 Mar;24(3):381-6. PubMed

Bodenheimer T. Coordinating care--a perilous journey through the health care system. N Engl J Med. 2008 Mar 6;358(10):1064-71. PubMed

Kripalani S, Lefevre F, Phillips CO, Williams MV, Basaviah P, Baker DW. Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. JAMA. 2007 Feb 28;297(8):831-41. [133 references] PubMed

Raval AN, Marchiori GE, Arnold JM. Improving the continuity of care following discharge of patients hospitalized with heart failure: is the discharge summary adequate?. Can J Cardiol. 2003 Mar 31;19(4):365-70. PubMed

The Joint Commission. Disease-specific care certification program. Advanced certification heart failure: performance measurement implementation guide. Oakbrook Terrace (IL): The Joint Commission; 2015 Mar. 76 p.

The Joint Commission. The Joint Commission's 2014 disease-specific care certification manual: advanced certification in heart failure addendum. Oakbrook Terrace (IL): The Joint Commission; 2014.

van Walraven C, Seth R, Austin PC, Laupacis A. Effect of discharge summary availability during post-discharge visits on hospital readmission. J Gen Intern Med. 2002 Mar;17(3):186-92. PubMed

Primary Health Components

Heart failure; care transition record

Denominator Description

All heart failure patients discharged from a hospital inpatient setting to home or home care (see the related "Denominator Inclusions/Exclusions" field)

Numerator Description

Care transition record transmitted to a next level of care provider within 7 days of discharge containing ALL of the following:

Reason for hospitalization

Procedures performed during this hospitalization

Treatment(s)/service(s) provided during this hospitalization

Discharge medications, including dosage and indication for use

Evidence Supporting the Measure

Follow-up treatment(s) and service(s) needed

Type of Evidence Supporting the Criterion of Quality for the Measure

One or more research studies published in a National Library of Medicine (NLM) indexed, peer-reviewed journal

Additional Information Supporting Need for the Measure

Unspecified

Extent of Measure Testing

Unspecified

State of Use of the Measure

State of Use

Current routine use

Current Use

not defined yet

Application of the Measure in its Current Use

Measurement Setting

Hospital Outpatient Transition Type of Care Coordination Coordination across provider teams/sites Professionals Involved in Delivery of Health Services not defined yet Least Aggregated Level of Services Delivery Addressed Individual Clinicians or Public Health Professionals Statement of Acceptable Minimum Sample Size Specified Target Population Age Age greater than or equal to 18 years Target Population Gender Either male or female National Strategy for Quality Improvement in Health Care National Quality Strategy Aim

National Quality Strategy Priority

Better Care

Ambulatory/Office-based Care

Home Care

Hospital Inpatient

Effective Communication and Care Coordination
Prevention and Treatment of Leading Causes of Mortality

Institute of Medicine (IOM) National Health Care Quality

Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Timeliness

Data Collection for the Measure

Case Finding Period

Discharges January 1 through December 31

Denominator Sampling Frame

Patients associated with provider

Denominator (Index) Event or Characteristic

Clinical Condition

Institutionalization

Patient/Individual (Consumer) Characteristic

Denominator Time Window

not defined yet

Denominator Inclusions/Exclusions

Inclusions

Discharges with International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Principal Diagnosis Code for heart failure (HF) as defined in the appendices of the original measure documentation, and

A discharge to home, home care, or court/law enforcement

Exclusions

Patients who had a left ventricular assistive device (LVAD) or heart transplant procedure during hospital stay ICD-9-CM procedure code for LVAD and heart transplant as defined in the appendices of the original measure documentation

Patients less than 18 years of age

Patient who have a Length of Stay greater than 120 days

Patients with Comfort Measures Only (as defined in the Data Elements) documented

Patients enrolled in a Clinical Trial (as defined in the Data Elements)

Patients discharged to locations other than home, home care, or law enforcement

Patients who left against medical advice (AMA)

Exclusions/Exceptions

not defined yet

Numerator Inclusions/Exclusions

Inclusions

Care transition record transmitted to a next level of care provider within 7 days of discharge containing ALL of the following:

Reason for hospitalization

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Treatment(s)/service(s) provided during this hospitalization

Discharge medications, including dosage and indication for use

Follow-up treatment(s) and service(s) needed

Exclusions

None

Numerator Search Strategy

Institutionalization

Data Source

Administrative clinical data

Paper medical record

Type of Health State

Does not apply to this measure

Instruments Used and/or Associated with the Measure

- Advanced Certification Heart Failure (ACHF) Initial Patient Population Algorithm Flowchart
- ACHF-03: Care Transition Record Transmitted Flowchart

Computation of the Measure

Measure Specifies Disaggregation

Does not apply to this measure

Scoring

Rate/Proportion

Interpretation of Score

Desired value is a higher score

Allowance for Patient or Population Factors

not defined yet

Standard of Comparison

not defined yet

Identifying Information

Original Title

ACHF-03: care transition record transmitted.

Measure Collection Name

Advanced Certification in Disease-specific Care Measures

Measure Set Name

Heart Failure Standardized Performance Measures

Submitter

The Joint Commission - Health Care Accreditation Organization

Developer

The Joint Commission - Health Care Accreditation Organization

Funding Source(s)

Unspecified

Composition of the Group that Developed the Measure

Unspecified

Financial Disclosures/Other Potential Conflicts of Interest

Unspecified

Adaptation

This measure was not adapted from another source.

Date of Most Current Version in NQMC

2015 Mar

Measure Maintenance

Unspecified

Date of Next Anticipated Revision

2015 Jul

Measure Status

This is the current release of the measure.

Source available from The Joint Commission Web site

The measure developer reaffirmed the currency of this measure in April 2016.

Measure Availability

For more information.	contact The	loint	Commission	at One	Renaissance	Blvd	Oakbrook	Terrace

For more information, contact The Joint Commission at One Renaissance Blvd., Oakbrook Terrace, IL 60181; Phone: 630-792-5800; Fax: 630-792-5005; Web site: www.jointcommission.org

NQMC Status

This NQMC summary was completed by ECRI Institute on May 21, 2015. The information was verified by the measure developer on June 15, 2015.

The information was reaffirmed by the measure developer on April 6, 2016.

Copyright Statement

This NQMC summary is based on the original measure, which is subject to the measure developer's copyright restrictions.

Production

Source(s)

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